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Government response to the recommendations regarding the draft Mental Health Bill

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The Mental Health Act 1983 (MHA) is the primary piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder. It was last updated in 2007.

In December 2018, an independent review of the MHA was chaired by Professor Sir Simon Wessely, the former president of the Royal College of Psychiatrists. The review found that the MHA could be reformed to provide a modern mental health service that respects the patient's voice and empowers them to shape their own care and treatment.

A draft Mental Health Bill was later published, containing proposals to reform the MHA. A Joint Committee (the Committee) was then appointed to consider the draft bill, and in January 2023 it published its report, containing numerous recommendations in relation to the draft bill. On 21 March 2024, the Government published its long awaited response to the Committee's report and its recommendations.

This article provides both a summary of the Government's response and a more in-depth analysis of some of the key recommendations that have been accepted and rejected by the Government.

The Government has committed to providing a revised bill, but at present, no formal timetable for this has been given. It is hard to see that a revised bill will be published before the general election, particularly given there was no mention of the bill in the 2023 King's Speech.

In summary

In total, the Committee made 55 recommendations to the Government regarding the draft Mental Health Bill. The Government has accepted or agreed to consider further a number of these, including:

- Reviewing the wording of the amended section 2 MHA detention criteria, in relation to "how soon" harm may occur.
- Considering how to ensure that Care (Education) and Treatment Reviews are conducted at "appropriate intervals" (i.e. more regularly than the maximum of 12 months, as currently provided for in the bill).
- Considering renaming the "risk register" as the "dynamic support register", and consulting with people with learning disabilities and autistic people to see how they can build trust in this mechanism.
- Placing a duty on services to "carry out activity" in relation to Advance Choice Documents (ACDs), exploring how to implement this initiative and how to store ACD information digitally, so that it can be shared easily and readily accessed.
- The need for greater clarity about holding powers in A&E departments.

The Government has however rejected several recommendations, including:

- The creation of a statutory mental health commissioner.
- The proposed abolition of Community Treatment Orders (CTOs) for patients under Part II of the MHA (civil patients) and a statutory review of CTOs for Part III (forensic patients).
- A standalone role of 'responsible person' to monitor inequalities.
- The extension of the new 'opt-out' approach for advocacy services to voluntary patients, and the creation of a specialised central advocacy service.

We have explored these in further detail below.

Which recommendations have been accepted or will be considered further?

Reviewing the wording of the amended section 2 MHA detention criteria

The draft Mental Health Bill seeks to amend the current wording of section 2 MHA, so that detention under this section can only take place if “serious harm” may be caused to the health and safety of the patient or another person and depending on “how soon” the harm may occur. This wording was included as the independent review found that some detentions are currently being justified by concerns about harms that may only occur far in the future.

The Joint Committee however recommended that the consideration of “how soon” harm might occur should not be included in the draft bill itself, but rather in the Code of Practice. Including this provision in the bill would be difficult for professionals on the ground to assess objectively and may dissuade potentially beneficial and shorter interventions at an earlier stage.

The Government has agreed to review the wording in the draft bill on 'how soon' harm may occur and to address the Committee's concerns about potential unintended consequences of the wording.

It will be interesting to see how the wording of this section evolves. The question of “how soon” is likely to be case specific, and dependent on a number of factors. It could also be a basis for a patient to challenge their detention.

Reducing maximum time periods between Care (Education) and Treatment Reviews

In 2015, Care (Education) and Treatment Reviews (C(E)TRs) were introduced for children and young people with learning disabilities and autistic people, who are in hospital or at risk of admission. These reviews are undertaken by commissioners and are intended to ensure that people are only admitted to hospital when absolutely necessary, and for the minimum amount of time possible.

The draft bill seeks to create a new Part 8A, putting C(E)TRs on a statutory footing and requiring them to be conducted “at least once in each successive 12 month period”. However, the Joint Committee recommended that the maximum time period between C(E)TRs should be shortened from 12 to six months. Although the draft bill also requires guidance on C(E)TRs to be published, which would specify when reviews should take place at shorter intervals, the Government recognises there is a risk that reviews will be carried out to the maximum timings set out in the legislation (12 months). It agrees that C(E)TRs should be conducted more frequently and is therefore “considering the best way of ensuring the individuals receive C(E)TRs at appropriate intervals.” This is welcome news, given that statistics from December 2022 revealed that there were 2,030 hospital inpatients who were either autistic and/or had a learning disability, and more than 50% of these inpatients had a total length of stay over two years.

Renaming the “risk register” as the “dynamic support register”, and consulting with people with learning disabilities and autistic people to see how they can build trust in this mechanism

The draft bill introduces a requirement for Integrated Care Boards (ICBs) to “establish and maintain” a register of people with learning disabilities or autistic people in their area who are at risk of hospital admission and monitor their care and treatment requirements. The Committee recommended that this proposed “risk register” should be renamed as the “dynamic support register”. This change in terminology is intended to shift the focus away from simply identifying risk towards providing support and assistance to those who need it, and to better reflect its purpose. The Government has agreed to consider this suggestion further.

The Government also agreed to consider the views of people with a learning disability and autistic people when developing statutory guidance on such registers, to ensure individuals feel able to trust the system.

Advance choice documents

Advance choice documents (ACDs) were recommended by the independent review, to allow a patient to record a range of preferences that they would like to be considered if they become unwell. ACDs can include care and treatment preferences, people they would like to be contacted and their wishes and feelings on more personal and practical matters. ACDs are considered to strengthen the patient’s voice, improve treatment and outcomes, increase clinical efficiency, improve communication and enhance decision making under crisis. Research also suggests they may reduce compulsory admissions by around 25%.

The Committee recommended a statutory right for detained patients to request an ACD be drawn up. These should be accessible, linked to the patient's GP records and usable quickly in crisis settings (e.g. by police and paramedics).

The Government agrees with the aims of this recommendation but believes that it is best achieved by "placing a duty on services to carry out activity in relation to ACDs" instead of introducing new rights for individuals to request them. The Government believes that this approach will be more effective as it places the onus on services to take action rather than individuals to 'request' ACDs. It is currently exploring how to implement this initiative and how to store ACD information digitally, so that it can be shared easily and readily accessed.

The need for greater clarity about holding powers in A&E departments

The Committee highlighted concerns about a "gap" in mental health care when individuals experiencing a crisis arrive in A&E departments, yet there is no statutory power to formally hold them. Neither the s.5 MHA "holding powers" (only available to in-patients – patients in A&E have not yet been admitted to hospital) nor the power to initiate the s.136 "removal to a place of safety" power can be used by clinical staff within A&E, meaning that if an individual is awaiting an MHA assessment, or has been assessed as needing mental health support under the MHA but is not already subject to s.136 or s.135 MHA, they are either free to leave or must be held under common law powers. This "gap" is exacerbated by a myriad of factors, such as long waiting times for mental health assessments, long waiting times for suitable beds, and a lack of a 'place of safety' in the meantime. The Committee therefore recommended that the Government should consult further on a short-term emergency detention power for A&E services.

The Government accepts that there may be a need to provide greater legal clarity to clinicians in A&E and will continue to engage with stakeholders to understand how the current legal framework is being applied and what, if any, legislative changes may be required. The Government also referenced the £150m of capital funding it has announced for crisis services, including £7m for mental health ambulances.

Which recommendations have been rejected?

There will be no creation of a statutory mental health commissioner

The Committee recommended the creation of a statutory mental health commissioner (and office), to be a voice at national level promoting the interests of those detained under the MHA, to work with CQC in reforming mental health law and to track the implementation of the reforms in the draft bill.

However, the Government rejected this recommendation, noting that CQC's wide remit already allows for a "holistic view of the health and social care sector, making it uniquely placed to identify and investigate potential issues." Additionally, at a "consumer" level, there are already statutory mechanisms in place to champion the voices of service users, such as independent mental health advocacy services and Healthwatch England.

The response of the Government will be disappointing to those who remain concerned that, as an organisation which is primarily a regulator, the CQC is not best placed to challenge the substance of the rules it enforces and may not be willing to 'rock the boat' by criticising the Government's approach or policies.

Community Treatment Orders (CTOs) will be reformed, not abolished

The independent review described CTOs as being "in the last chance saloon". The Committee noted that they were being used more than intended, and used disproportionally for black and ethnic minority patients. It recommended that CTOs be abolished for patients under Part II of the MHA (civil patients). For unrestricted Part III (forensic) patients, the Committee recommended a statutory review of CTOs within three years to assess their value, with automatic abolition six months later unless the review demonstrated that CTOs had value and were now being used in a non-discriminatory way.

The Government has rejected the proposed abolition of CTOs, arguing that if CTOs are not available, some patients may spend longer in hospital, or there could be a greater use of section 17 leave which does not have equivalent safeguards. It sees no need to differentiate between Part II and unrestricted Part III patients.

The Government considers that the reforms set out in the draft Mental Health Bill seek to address concerns about people being on a CTO for far too long and the disproportionate number of black people being made subject to a CTO. In particular, the Government has said that under the draft bill, CTOs can only be used where there is "strong justification and a genuine therapeutic benefit for the patient". The community clinician will need to be involved in CTO decisions and care arrangements and the tribunal will also be able to recommend reconsideration of a particular CTO condition. The Government commits to monitoring the impact of these changes, particularly in relation to racial disparities.

A possible (though not distinct) role of 'responsible person' to monitor inequalities

Drawing a parallel with the role created under the Mental Health Units (Use of Force) Act 2019 to oversee and monitor the use of physical, mechanical and chemical restraint, the Committee had supported the creation of a statutory position of 'responsible person' within each relevant organisation. Their role would be to ensure that policies and training were in place to prevent and reduce biased decision making, and to collect and monitor data on MHA detentions, broken down by ethnicity and other demographic details. The Government would be obliged to publish these statistics.

The Government's response regarding the proposed 'responsible person' seems lukewarm. It says that tackling disparities in the application of the MHA is a priority and says that it will consider the recommendation further, but makes clear that it would be a bolt-on to an existing senior person's role rather than a new position. There is no specific response regarding the responsible person's duties.

Advocacy – so far but no further as yet

Partially implementing one of the recommendations of the Independent Review, the draft bill introduces a requirement for hospital managers to notify the appropriate independent mental health advocacy service when a patient is detained. The independent mental health advocacy must then visit the patient to establish whether they require the independent mental health advocacy's assistance (or, if the patient lacks capacity, if independent mental health advocacy involvement is in their best interests). This represents a change from the current 'opt-in' arrangement, under which detained patients must be informed of their right to an independent mental health advocacy but must request to see one. Voluntary patients will gain a right to 'opt-in' to the services of an independent mental health advocacy, but would not be pro-actively offered assistance.

The Committee recommended that, once there was enough capacity in the advocacy sector, the new 'opt-out' approach should be extended to voluntary patients (which includes many child patients), but the Government has said that it will not take this forward.

The Independent Review also highlighted that advocacy support is poor at proactively engaging ethnic minority people. It recommended that culturally-appropriate advocacy should be provided for people of all ethnic backgrounds, in particular for the black African and Caribbean community. The Government ran Phase I culturally-appropriate advocacy pilots in 2021 and 2022, and began Phase II pilots in December 2023.

While the Committee recognised that the Government would need to complete the Phase II pilot, it had nevertheless recommended a statutory right to culturally-appropriate advocacy. However, the Government wants to wait for the outcomes of the current pilots before deciding whether, as well as how, to introduce this.

The Committee had also received evidence that specialist advocacy services were needed for people with learning disabilities and autism, and for children and young people. It recommended that the Government consider creating a specialist central advocacy service to fill the gap in existing services. However, the Government has decided not to create such a service. It perceives the benefits of advocacy services being local to the patient and emphasises that existing law imposes a legal duty on current advocacy providers to make reasonable adjustments to meet the needs of those they are supporting. It has however said that it will work with the sector to provide training and improve skills to improve provision.

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